WHITMAN-WALKER HEALTH
we see you.

Legal Server Case #_____

Medicare Part D Intake 2019

CLIENTS: Please complete the following information in preparation for your meeting with the attorney

In order to best serve you, an attorney will need to create a free online MyMedicare account. We will use the information you provide to create an account and assign you a username and password which we will share with you following our help.

NAME (name you use):_____ **Pronouns:**_____

Full LEGAL Name (if different):_____ **Language**: _____

Address:_____
(Number, Street, Apt./Suite) (City) (State) (County) (Zip)

Medicare ID: _____-_____-_____

Date of Birth: _____

Pharmacy (include location):

_____

Phone: _____

Email Address:_____

Social Security Number: _____-_____-_____

Additional Medicare Information:

Part A ☐ **yes** ☐ **no** **Effective date:** _____
Part B ☐ **yes** ☐ **no** **Effective date:** _____
Part D ☐ **yes** ☐ **no** **If yes, plan name:** _____

Medicare Advantage (HMO-Medicare) ☐ **yes** ☐ **no**
If yes, what plan?_____
Do you also have private health insurance? ☐ **yes** ☐ **no**
If yes, what plan? _____

Sex Assigned at Birth:	**Gender Identity:**	**Sexual Orientation:**	**HIV Status:**	**Are you a Military Veteran?**	**Total Monthly Income (*including spouse*):**
□ Female □ Male □ Intersex	□ Female / Woman / Transwoman □ Male / Man / Transman □ Genderqueer / Non-binary □ _____	□ Bisexual or Pansexual □ Lesbian, Gay, Same Gender Loving □ Straight/Heterosexual □ Decline to Answer/ Unable to Obtain □ _____	□ Positive □ Negative or Unsure	□ Yes □ No	$_____ □ SSDI □ SS Retirement □ SSI □ Work □ Other _____
			Are you legally married? □ Yes □ No		

LIST YOUR PRESCRIPTION DRUGS

Prescription Drug Name	Dosage	# of pills /day

□ **Please check here if you are attaching a separate or additional list of medications**

*** Attach a copy of your Medicare (red, white, and blue card).**

By signing below, you are attesting that the information on this page is correct and are giving consent for a WWH attorney or volunteer to create a MyMedicare Account for the purposes of assisting you with selecting a Part D plan.

CLIENT SIGNATURE: _____ **DATE:** _____

WWH STAFF ONLY

Medicaid: ☐ **yes** ☐ **no** ☐ **n/a**
Recert Date: _____

QMB: ☐ **yes** ☐ **no** ☐ **n/a**
Recert Date: _____

LIS: ☐ **yes** ☐ **no** ☐ **n/a**
Recert Date: _____

ADAP: ☐ **yes** ☐ **no** ☐ **n/a**
Recert Date: _____

Did Client meet with PBIN?
☐ **Yes** ☐ **No**
When? _____

PBIN Initials: _____

WHITMAN-WALKER HEALTH

2019 Medicare Part D Notes

ATTORNEY COMPLETION ONLY: Please complete the following information completely.

Volunteer Name: _____ **Phone:** _____

Law Firm: _____ **E-mail:** _____

Action Taken by Volunteer Attorney or WWH Staff:

1. How did you assist the client? ☐ In-person ☐Telephone ☐E-mail
2. ☐ On the medicare.gov website, I have created a MyMedicare account: Username: _____ Password: _____ and conducted a personalized; **or**

   ☐ I was unable to create a MyMedicare account and was only able to do a generalized plan search.
3. Create a medications list, or confirm the existing drug list with the client and print a copy of the medication list.
4. ☐ I printed the plan details for the client's current/default plan for 2020; **or**
   ☐ The client's 2019 plan has been discontinued for 2020 (and no default plan was listed).
5. Complete the plan analysis. Be sure to consider the monthly premium ($0 for LIS, preferably), annual drug cost, drug restrictions, and pharmacy network for the client.

Summarize your findings and analysis

2020 Plan Recommendation: _____ ☐ Same Plan/No Change

Current/default plan: Monthly Premium Amount $_____ New plan: Monthly Premium Amount $_____

Current/default plan: Estimated Annual Drug Costs 2020 $_____ New plan: Estimated Annual Drug Costs 2020 $_____

☐ I have attached the plan details for the recommended plan for 2020, including any drug restriction details.

6. Did you need to call the plan? ☐ Yes ☐ No
   If yes, why?_____
   Number called _____Name of service representative _____
7. Review your plan recommendation with a supervisor. **Supervisor Initials**_____
8. Did you enroll the beneficiary in a plan? ☐ Yes ☐ No Enrollment Date: _____
   If **yes**, was it the recommended plan? ☐ Yes ☐ No, why? _____
   Why did the client change plans? _____
   ☐ I printed a copy of the enrollment grid containing the client's personal information.
   ☐ I printed a copy of the "Enrollment Successful" confirmation page.

   If **no**:
   ☐ I counseled the client to stay in the current/default plan for 2020.
   ☐ There is follow-up required for this plan analysis, as follows:

   _____

   _____
9. Please provide your client a take-away form and copies of the plan details/enrollment.
   ☐ I gave the client a copy of the take-away form, plan details, and enrollment confirmation.
   ☐ I completed and saved the MyMedicare account template
   ☐ I attached a copy of the take-away form, plan details, MyMedicare account template, and enrollment confirmation to this intake for WWH.

Follow-Up Action Provided by:_____ Date:_____

Any other action taken? ☐ Yes ☐ No If yes, please describe below.